NJ DIVISION OF MENTAL HEALTH SERVICES
REQUEST TO DISCHARGE LIEN

Please mail this completed form to the State Psychiatric Hospital where services were provided. If you have liens from more than one psychiatric hospital, a separate request must be made to each hospital. Please refer to the "State and County Hospital Contacts" list to find the most current mailing information for State and telephone contact information for County Psychiatric Hospitals.

CLIENT INFORMATION: (Client can be either a former patient or a Legally Responsible Relative (LRR) with a hospital-filed lien in their name)

NAME: _____

CURRENT ADDRESS: _____

_____

DAYTIME PHONE NUMBER: _____

COUNTY OF RESIDENCE: _____

SS#: XXX-XX-__ __ __ __ DATE OF BIRTH: _____

DATES/YEAR SERVICE PROVIDED AT THE HOSPITAL RECEIVING THIS REQUEST (if known):

_____

_____

_____

HOME ADDRESS DURING ADMISSION (if known):

_____

_____COUNTY: _____

AVAILABLE INFORMATION FOR THE LIEN(S) FILED BY THE HOSPITAL RECEIVING THIS REQUEST: (If you have any of the information below, or copies of lien(s) that you are requesting to be discharged, please provide it for each lien filed for inpatient services at the hospital receiving this Request. Additional pages may need to be attached.)

STATE SUPERIOR COURT CLERK FILED: Y/N _____ DOCKET NUMBER: _____

COUNTY WHERE LIEN FILED: _____

LIEN NUMBER: _____

BOOK NUMBER: _____ PAGE NUMBER: _____

DATE OF LIEN: _____ DATE LIEN RECORDED: _____

SIGNATURE OF CLIENT (patient or LRR) LIENED:

_____ DATE: _____

Or Name of the Client Liened _____

And signature of an individual with authority to sign on behalf of the liened person, together with proof of: P.O.A.; Guardianship; Administrative powers over the Estate:

_____ DATE: _____

RELATIONSHIP TO CLIENT: _____